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1. INTRODUCTION

A. OVERVIEW

All Providers will complete a cost report using the prescribed format for a twelve-month period. The purpose of the cost report is to define the cost of each service by service center. The cost report is comprised of Schedule A - Expenses and Schedule B - Revenues, along with three attachments. The horizontal axis of the cost report depicts all service centers as well as the "Total" and "Adjustment" columns. The vertical axis represents various accounts. Schedule A has a Chart of Accounts unique to Schedule A and Schedule B has a Chart of Accounts unique to Schedule B. The cost report must be completed on an accrual basis of accounting.

Information to complete the cost report may come from various sources depending on each agency's method of tracking various costs. Personnel, payroll, provider expense records, and activity logs, are examples of tools that may be used to compile information to complete the cost report.

B. GENERAL GUIDELINES

1. Deadline: The deadline for returning the required annual cost report to the Department is four months after the reporting period. All incomplete or incorrect reports will be returned to the provider for corrections.

2. Contents: The complete annual cost report includes: cover sheet, Schedules A and B, Attachments A, B, and 1. These forms will cover the agency's twelve-month fiscal year.

3. Method of Submission: Schedules A and B and Attachments A and B shall be included in the annual entity wide audit as prescribed in Sections 3 and 4. Schedules A and B, Notes to Schedules A and B and Attachment 1 shall be submitted directly to the Department of Human Services via email. Please use the following naming conventions when submitting the files: **AgencyName_Schedules.xls** and **AgencyName_Attachment1.xls**. *AgencyName* should be the full or abbreviated name of your agency.

   Examples:
   BMS_Schedules.xls (Behavior Management Systems)
   SHAD_Attachment1.xls (Southern Hills Alcohol and Drug)

4. Use of columns: A separate column shall be used for each service center.

5. Use of lines: Report expenses and revenues on the appropriate line based upon the nature of the item.

6. Supporting Documentation: All expenses and revenues reflected on these forms must be supported by the provider's general ledger. Worksheets or an explanation that reasonably justifies the entry must support adjusting journal entries. All records and worksheets used in preparing the reports must be readily available for audit.

7. Rounding: All costs reported on Schedule A are to be gross costs and rounded to the nearest dollar

8. Adjustments: The Adjustment Column may be used to report items included in the audited Financial Statements that may not actually be allowable expenses or reportable revenues to service centers. Examples could be non-allowable costs.

C. FINANCIAL REPORTING REQUIREMENTS

1. Records

a. The provider shall maintain on the premises the required service records and financial information sufficient to provide for a proper audit or review including documentation to support the rationale for direct assignment to specific service centers or the allocation to numerous service centers. Sufficient data must be available as of the audit date to fully support any item being claimed on the cost report.

b. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

c. Records must be retained for six years following the submission of the cost report. Records relating to unresolved audits must be retained until final resolution of the audit. Records must be available upon reasonable demand to representatives of the Department and/or Attorney General's Medicaid Fraud Unit (MCFU) and/or to the US Secretary of Health and Human Services or representatives thereof.

2. Accounting and Reporting Requirements

a. The accrual basis of accounting must be used for reporting purposes.

b. The accounting system must be structured so that cost accounts are grouped by service center and traceable to the cost report.

c. Generally accepted accounting principles must be followed unless the Department specifies alternative treatment.

d. Costs reported must include all actual costs and adjustments for non-allowable costs. The Department will forward all items identified as fraudulent or abusive to the Attorney General's Medicaid Fraud Unit.

e. Costs must be allocated by the method identified in the Instructions for Schedule A – Expenses for services used for more than one operational program, administration or non-allowable activity. The following pertains to DD providers only: During reporting periods where activity logging is not required, time study or an alternate method of allowable allocation must be performed.

f. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally accepted accounting procedures will be used in determining the life of any addition(s) to primary structures.

g. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

Depreciation on major movable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviations from AHA Guidelines may be granted in those instances in which providers can furnish the Department with documented historical proof of useful life.

h. Funded Depreciation Accounts

1. A funded depreciation account can be established for the replacement of capital assets and can be funded at a rate not greater than current annual depreciation.

2. The establishment of the fund and the procedures governing the fund must be specifically approved by the agency's board of directors.

3. The approved procedures must stipulate the rate by which the account will be funded and shall delineate the items to be purchased with the fund.

4. Agencies must use the account for the purchase of capital items as defined by their internal procedures. Transfers from the funded depreciation reserve account will be allowed for necessary cash flow purposes as long as the transfer does not cause the agency to exceed operating reserve standards set forth in the Cost Report Preparation Guidelines (see Reserve Funds policy, page 7).

5. Agencies with funded depreciation accounts shall use the following format for their annual audited financial statement. Funded depreciation accounts will be recorded:
   a. in the Assets section under the heading "Designated for Capital Asset Replacement". The amount may appear in various places in the Assets section depending on whether the money is in a checking account, Money Market fund, CD's, Time Deposits, etc. or
   b. in the Unrestricted Net Assets section under the heading "Designated for Capital Asset Replacement".

i. No reimbursement shall be allowed for additional costs related to sub-leases.

3. Auditing

The provider shall have an annual entity-wide independent audit covering the same reporting period as the cost report. Worksheet entries reconciling the cost report to the audit shall be prepared either by the agency or the auditor and shall be included with the cost report (see Page 22, Notes to Schedule A and Notes to Schedule B). The audit shall be submitted to the Department of Human Services.

A-133:
If applicable, audits shall be conducted in accordance with OMB Circular A-133 by an auditor approved by the Auditor General to perform the audit. Approval may be obtained by forwarding a copy of the audit engagement letter to:

Department of Legislative Audit
A-133 Coordinator
427 South Chapelle
c/o 500 East Capitol
Pierre, SD 57501-5070

On continuing audit engagements, the Auditor General's approval should be obtained annually. Audits shall be completed and filed with the Department of Legislative Audit by the end of four months following the end of the fiscal year being audited.

Failure to complete audits as required will result in the disallowance of audit costs as direct or indirect charges to programs. Additionally, a percentage of awards may be withheld until the audit is completed satisfactorily, overhead costs may be disallowed, and/or awards may be suspended until the audit is made.

4. Submission of Audit:

a. A copy of the completed audit report shall be provided to the Department by the end of four months following the end of the fiscal year being audited.

b. The cost report shall be tested by an independent auditor and a statement indicating such should be included in the audit report.

c. Cost Report forms (Schedules A and B) shall be included in the paper audit report, Supplementary section, and shall also be submitted to the Department electronically via email. Testing requirements for sub-categories on Schedule A are as follows:

1. Personnel Services: If expenses charged to this area of the cost report (Total column, TOTAL PERSONNEL SERVICES) are 65% or greater of total agency expenses on Schedule A, the sample test size shall be 10 employees. Of these two (2)

shall be Administrative staff and eight (8) shall be Professional staff. If expenses charged to this area of the cost report are less than 65% of total agency expenses, the sample test size shall be five (5) employees. Of these one (1) shall be Administrative staff and four (4) shall be Professional staff.

2. Personnel Benefits and Taxes: Test allocations for the same employees selected for Personnel Services testing.

3. Professional Fees and Contract Services: If expenses charged to this area of the cost report (Total column, TOTAL PROFESSIONAL FEES AND CONTRACT SERVICES) are 6% or greater of total agency expenses on Schedule A, the sample test size shall be six (6) transactions. If expenses charged to this area of the cost report are less than 6% of total agency expenses, the sample test size shall be three (3) transactions.

4. Travel/Transportation: If expenses charged to this area of the cost report (Total column, TOTAL TRAVEL/TRANSPORTATION) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

5. Supplies: If expenses charged to this area of the cost report (Total column, TOTAL SUPPLIES) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

6. Occupancy: If expenses charged to this area of the cost report (Total column, TOTAL OCCUPANCY) are 7% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 7% of total agency expenses, the sample test size shall be one (1) transaction.

7. Equipment: If expenses charged to this area of the cost report (Total column, TOTAL EQUIPMENT) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

8. Depreciation: If expenses charged to this area of the cost report (Total column, TOTAL DEPRECIATION) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged

to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

9. Miscellaneous: If expenses charged to this area of the cost report (Total column, TOTAL MISCELLANEOUS) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

5. Filing Extensions

a. No automatic extensions for filing of the annual cost report or audit report will be made. All requests **must** be in writing and **must** be received by the Department at least 10 working days prior to the due date.

b. Requests must clearly explain the reason for the extension and identify the date on which the report will be submitted.

c. Approval of extensions will be granted for good cause at the sole discretion of the Department. The provider will be notified in writing of the approval or denial. A "good cause" is one that supplies a substantial reason, affords a legal excuse for the delay, or an intervening action beyond the provider's control. The following are not considered "good cause": ignorance of the rule, inconvenience, and/or a cost report preparer and/or independent public accountant is engaged in other work.

d. Amendments to reported costs will not be allowed after the cost reports have been used to determine rates.

6. Reserve Funds Policy

Reserve funds (excluding restricted trust or endowments, and/or funded depreciation accounts) shall not exceed 90 days total operating expenses. The Department calculates agency reserves using information reported in the annual independent audited financial statements. The formula for calculating reserves is: Reserves = (Unrestricted Funds – Funded Depreciation and Endowments). Sinking funds specifically reserved for building or equipment replacement may be excluded to the extent it was accumulated at the authorized depreciation rate (see Accounting and Reporting Requirements, page 3). If reserves exceed 90 days total operating expenses, provider must submit a plan to the Department for re-investing the excess into the program. The Department will notify the provider of approval or disapproval within 30 days.

7. Recording of Service Units

The provider must maintain a record of all service units as required by the Department.

8. <u>Cost Allowability and Limitations</u>

Any questions regarding cost allowability and limitations will be governed by Title XIX of the Social Security Act unless further limited by these guidelines or the purchase of service agreement.

9. <u>Non-allowable Costs</u> - Include, but are not limited to:

a. Advertising, public relations, and clothing expenses as identified by HCFA-15.

b. Costs which have not been incurred by the agency, including the value of donated goods and services.

c. Bad debts are a deduction from the applicable Service Center rather than a reimbursable expense item and should be reported in the adjustment column.

d. Costs incurred solely to enhance income from investments.

e. Cost of securing contributions or donations.

f. Depreciation costs for idle facilities except when such facilities are necessary to meet caseload fluctuations.

g. All dues and costs associated with individual or agency memberships to fraternal organizations, service organizations, country clubs, etc.

h. Fines and penalties resulting from failure to comply with Federal, State and local laws.

i. Finance, late charges and the following items of interest expense are not reimbursable:

1. Funds borrowed for investment purposes;

2. Funds borrowed to create working capital in excess of two months operating costs;

3. Funds borrowed for the personal benefit of employees, officers, board of directors, members, or owners of the provider agency;

4. Funds borrowed without a prior time-limited written agreement with the Department for the purchase of land or buildings, until such items are actively used in program activity; and,

5. Interest charges made for intra-agency loans between funds are not a reimbursable expense. An agency is defined as an organizational entity with a single Federal Employer's Identification Number.

j. Entertainment costs for activities including staff only. Examples include holiday parties not involving consumers, flowers or other gifts for staff.

k. Taxes (see page 11, **a. Taxes**).

l. Telephone costs attributable to personal usage by employees and consumers.

m. All costs associated with payment to registered lobbyists.

n. Costs associated with charity, grants, and professional discounts. Charity is defined as the donation of cash or in-kind services to other organizations and individuals external to the provider. Grants are defined as awards to organizations, programs and/or individuals external to the provider.

o. Meals consumed by guests and staff when staff attendance with the consumer is not programmatically mandatory. This does not prohibit this expense for live-in staff. Meals are allowable as part of required travel for staff.

p. Any expense incurred by the provider for the sale of goods or services (example: production).

q. Cost of car reserved only for agency director.

r. Costs associated with depreciation of equipment/buildings obtained with monies (i.e., grants, for example Department of Transportation) not allowing subsequent year's depreciation.

10. Parent-Subsidiary/Related Organizations (Specify on Attachment A)

a. Costs applicable to services, facilities, and supplies furnished to a provider by a parent-subsidiary/related organization, shall not exceed the lower of the cost to the parent-subsidiary/related organization or the price of comparable services, facilities, or supplies purchased elsewhere, primarily in the local market. Providers must identify such parent-subsidiary/related organizations and costs in the cost report and include an appropriate statement of costs and allocations with the cost report. Umbrella or chain organizations are also considered parent-subsidiary/related organizations. Management fees will be considered administrative costs for cost reporting purposes.

b. Home offices of parent-subsidiary/related organizations vary greatly in size, number of locations, staff, and services furnished to their member facilities. Although the home office is normally not a provider in itself, it may furnish to the individual provider central administration or other services, such as centralized accounting, purchasing, personnel, or management services.

Only the home office's actual cost of providing such services may be included in the provider's allowable costs under the program. In order to be considered an allowable cost, the home office costs must be directly related to those services performed for individual providers and relate to consumer services. Documentation as to the time spent, the services provided, the hourly valuation of services, and the allocation method used, must be available to substantiate the reasonableness of the cost. Any services provided by the home office which are included in costs as payments to an outside provider, will be considered a duplication of costs and not be allowed.

c. Rental expense for buildings and equipment that do not exceed actual cost for these items and that are necessary to provide program services to recipients, are an allowable expense.

11. Gifts and Income from Endowments

a. Unrestricted gifts and income from endowments will not be deducted from operating costs in computing reimbursable cost. Gifts or endowment income designated by a donor for paying specific operating costs incurred in providing contract services will be deducted from the particular program operating cost or group of costs.

b. Period in Which Funds Are Deemed Used. The terms of the contribution may specifically state the period of time during which the funds are to be applied. When specific periods of time are not provided, restricted contributions are deemed to be used in the reporting period in which the gift is received to the extent that applicable costs are incurred after the date of the gift. Generally, the donor of a restricted contribution intends that the provider use the funds for the purpose for which they were given; therefore, the above order of application is in accord with the purposes of the gift. Restricted contributions not used in the reporting period in which they were received are carried over into the following period, or periods, and used for the designated purpose.

Assume that a provider incurred $10,000 cost for transportation services during a calendar year reporting period. On July 1, they received a contribution of $10,000 which was designated by the donor to be used to provide transportation services for all consumers. Examination of the costs of these services indicates that costs of $4,000 were incurred after July 1. Under the principles of reimbursement, allowable costs shall be computed as follows:

Total costs of transportation services for the period	$10,000
Portion of costs incurred after date of gift (July 1)	4,000
Allowable costs for the reporting period	$ 6,000

The amount of restricted contribution would be adjusted as follows:

Contribution as of July 1	$10,000

Appropriate costs incurred subsequent to date of gift	4,000
Balance of restricted contribution at end of reporting period.	$ 6,000

The balance would be applied to the costs incurred for transportation services during the subsequent reporting period(s).

12. Taxes

a. Taxes assessed against the provider, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs.

b. The following taxes are not allowable as costs:

1. Federal income and excess profit taxes, including any interest or penalties paid.

2. State or local income and excess profit taxes.

3. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not recognized as tax expense.

4. Taxes from which exemptions are available to the provider.

5. Special assessments on land which represent capital improvements, such as sewers, water and pavements, should be capitalized and may be depreciated.

6. Taxes on property which is not used in the provision of covered services.

7. Tax expense may not include fines or penalties.

8. Self-employment taxes.

2. COST REPORT: SCHEDULE A - EXPENSES

Columns and rows highlighted in gray (on the templates) are completed by DHS staff.

A. HORIZONTAL AXIS: TOTAL AND ADJUSTMENT COLUMNS/SERVICE CENTERS

The horizontal axis contains the Total, Adjustments, Administration and Support and Fund Raising columns as well as the program services unique to each provider group (Developmental Disabilities, Alcohol and Drug Abuse, Mental Health and Rehabilitation Services). Following is a list of definitions for the Total, Adjustments, Administration and Support, Fund Raising and Other Services columns. You can find a list of the program services for each provider group in Appendices A, B, C and D.

Total - This column represents the total expenses from the operating statement of the organization for the reporting period. The total of the expenses must reconcile to the independently audited financial statements.

Adjustments - This column represents additions or deletions from the total column of an account for costs that do not represent a cost to a service center, or are considered non-allowable **(see list of Non-Allowable costs on pages 8 and 9)**.

Administration and Support - Includes expenditures for the overall direction of the organization, general record keeping, business management, budgeting, general board activities, and related purposes. Direct supervision of program services and of fund raising should be charged to those functions. Overall direction will usually include the salaries and expenses of the chief officer of the organization and his/her staff. If they spend a portion of their time directly supervising fund-raising or program services and activities, such salaries and expenses should be prorated among those functions.

Fund Raising – Expenditures normally charged to this function include costs of transmitting appeals to the public (including postage, addressing, maintenance of mailing lists and other fund drive records) and the salaries of staff members connected with fund raising for the agency, capital campaigns, foundations, etc. An appropriate portion of the salaries of regular staff members who devote time to record keeping for fund raising should be allocated to fund raising expenses.

Other Services - Use these columns for reporting expenditures for services other than those listed in appendix A, B, C or D not purchased by the Division of Developmental Disabilities, Division of Mental Health, Division of Alcohol and Drug Abuse or Division of Rehabilitation Services.

B. VERTICAL AXIS - CHART OF ACCOUNTS

Costs should be allocated by direct assignment to Administration and Support or the benefiting service center based on time study or activity logging unless otherwise indicated.

1000 - PERSONNEL SERVICES

1010 - **Administrative:** Administrative staff are personnel who manage/direct the overall or specific programs of the agency. Administrative staff make policy decisions, do agency wide training and do not spend more than 10% of their time doing direct service.
Please Note: If an individual spends more than 10% of their time doing direct service, they should be listed under 1020 – Professional/Program Staff.

Examples:

President/CEO	Finance Director
Executive Director	Business/Office Manager

1020 - **Professional/Program Staff:** Professional/program staff are personnel who may be certified/licensed and provide services related to their profession. Professional/program staff are those personnel who are necessary to provide basic program services.

Examples:

Social Worker	Job Coach
Counselor (CD, MH, DD, REHAB, etc.)	Physician
Registered Nurse	Licensed Practical Nurse
Teacher	Staff Development
Residential Instructors/Aids	Supported Living Instructors

1040 - **Support Staff:** Support staff are personnel who do not provide direct service to individuals served, but support the daily operations of the agency.

Examples:

Office Staff (Admin. & Support)	Custodial Staff (Sq. Ft. or Direct)
Adaptive Equipment Specialist	Nursing Secretaries

1050 - Consumer Wages: Wages paid to consumers for work performed in or for the facility.

Example: Wages paid for in-house janitorial work would be reported under the appropriate service center.

Direct Assignment to Production or benefiting service center. (Example: In-house janitorial allocation based on square feet).

1060 - Temporary Staff: Staff hired for a temporary period of time. The personnel costs associated with these individuals are reported on Schedule A. The hours and wages for these individuals should not be reported on Attachment 1.

Examples:

Staff hired to fill-in or cover for administration or support staff on maternity leave, FMLA, extended disability, etc.

Staff hired for a short-term project. These staff are supplements to existing staff and do not provide direct care (i.e. staff hired to do production work along side people served in a workshop to meet production deadlines, staff hired for a grant position that is short lived and will not continue, or staff to provide summer maintenance/yard work).

Staff hired as on-call or relief direct care staff. These staff fill-in when a full-time direct care staff uses vacation or sick leave or other times as needed (i.e. additional staff needed due to illness or behavior of people served). The number of on-call staff and the hours available for them to work varies at any point in time.

1090 - Payroll Accruals: Payroll accruals must be reported here. Provide an explanation of any amounts reported in this account on Attachment A - Notes to Schedule A.

1100 - PERSONNEL BENEFITS AND TAXES

1110 - Retirement Plans: The cost of agency contributions to employee retirement plans.

1120 - Insurance Benefits: The cost of items such as health, life, disability and dental insurance coverage for agency staff.

1130 - Other Benefits: The cost of employee benefits which are not included above. Examples include childcare, educational benefits, staff appreciation (other than wages), employee physicals, Hepatitis B and TB testing. Identify on a separate schedule the type and cost of each benefit by staff member.

1140 - FICA Taxes: Represents the FICA tax expense to the agency, to include Medicare amount.

1150 - Unemployment Insurance: The cost of State and/or Federal unemployment insurance.

1160 - Worker's Compensation Insurance: Represents the agency's Worker's Compensation Insurance premium.

1170 - Professional Liability Insurance: Represents the cost of liability insurance premiums related to coverage for actions/omissions of employees and/or board members (protection against fraudulent or dishonest acts by officers or employees).

1190 - Other: If the amount reported in the total column for this account equals or exceeds 5% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

1200 - PROFESSIONAL FEES & CONTRACTUAL SERVICES

Services obtained from non-agency professionals in each of the following areas.

1210 - Administrative/Financial: Represents the cost of financial, accounting or data processing professionals, including software support agreements. Includes the following:

Audit Services: Represents the cost of an independent audit of the agency. *Direct assignment to Admin. & Support*
Legal Services: Represents the cost of attorney or legal services. *Direct assignment to Admin. & Support for personnel or property; otherwise direct assignment to benefiting service center*
Advertising/Public Relations: Represents the cost of advertising for staff, publication of legal notices and public information. Examples include yellow-page ads, printing of informational leaflets or brochures and newsletters. *Example: Fund raising to Fund Raising, advertising for a position to the benefiting service center*
Dues/Memberships/Subs./Ref. Materials: Represents amounts paid for membership in organizations, costs for subscriptions, and reference and resource publications purchased for use by the agency. *Example: Physician's Desk Reference Nursing Services, SDaCBS to Admin. & Support, Council of CMHC Directors to Administration*
Registration Fees: Represents the registration costs of conventions, conferences and meetings.

1220 - Habilitation/Rehabilitation: Costs associated with services obtained from non-agency professionals such as a special education teacher, certified vocational evaluator, psychologist, recreational therapist and social worker.

1230 - Medical Services: Obtained from non-agency professionals in each of the following areas:

1231- Other Medical: Costs associated with services obtained from non-agency professionals for the following: Dental, Dietary, Occupational Therapy, Physical Therapy, Optometric, Pharmacy, Speech Pathology and Audiological Services.

1237 - Physician/Nursing Services: Costs associated with physician and nursing services obtained from non-agency professionals (including the cost of lab reports).

1238 - Psychiatric Services: Costs associated with psychiatric services obtained from non-agency professionals.

1290 - Other Professional Services: Costs for services obtained from non-agency professionals not identified in accounts 1210 through 1238. Examples include architectural or engineering services, costs incurred with outside speakers, meals, motels, fees, etc.
Please Note: If the amount reported in the total column for this account equals or exceeds 20% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

1300 - TRAVEL/TRANSPORTATION

1390 - Other: Represents the cost of mileage payments to staff, consumers (token/tickets), board members, volunteers, transportation providers and others and the cost of repairs, maintenance, insurance, lodging, meals and other travel costs. Examples include short-term rentals for automobiles, parking fees, airfare, bus or taxi fares, and mass transit. Report principal payments related to the purchase of vehicles and lease payments meeting capitalization guidelines in the 1700 series. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the

agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

1400 - SUPPLIES

1440 - Food: Represents all costs associated with the purchase of consumable foods and related dietary items such as nutritional supplements. This includes the value of commodities. Report nutritional supplements under the Medical Equipment and Drugs service center. *Direct assignment to Food Service or benefiting service center*

1490 - Other: Represents other supply costs such as office, program/instructional, medical, postage and shipping, and production. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

1500 - OCCUPANCY

1510 - Rent of Space: Cost of rental payments for land, buildings, office, or residential space used for the operation of the agency. *Direct assignment to benefiting service center based on square feet*

1520 - Utilities & Telephone: The cost of a public service, unless the cost is included in rent. Utilities include heat, lights, water, gas, electricity, waste removal, and cable TV (*direct assignment to benefiting service center based on square feet)*. Telephone includes the cost of monthly service and long-distance fees (*direct assignment to benefiting service center for monthly service per phone, long distance to benefiting service center).*

1590 - Other: The cost associated with mortgage interest, insurance, taxes, buildings and grounds, maintenance and other occupancy costs. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

Note for DDD Providers only: *Day Services (Service Center 06): Recognition of additional occupancy costs (Accounts 1510-1590) and Depreciation costs (Account 1710)*

An adjustment is necessary to transfer a portion of the occupancy costs within the Production center to Day Services. The process is as follows:

a. *Determine the Percent of Norm for each consumer and the average of the total for all consumers being trained in a production area within the agency.*
b. *Multiply the Inverse Percent of Norm for all consumers (determined in "a" above) by the total occupancy costs for the Production center.*
c. *The amount of occupancy costs identified in "b" (above) is reduced from the Production occupancy costs and added to the Day Services occupancy costs.*

1600 - EQUIPMENT

1600 - Purchase, Rental, Leases, Maintenance: The cost of equipment acquired with a per unit cost of less than $1,000, rental payments for equipment/vehicles used for the operation of the agency and costs associated with the repair or maintenance of agency equipment.

1700 - DEPRECIATION

1710 - Building: Annual cost associated with the depreciation of agency office, program or residential facilities pursuant to American Hospital Association (AHA) Guidelines. *Direct assignment to benefiting service center based on square feet.*

1720 - Equipment: Item cost (if per unit cost greater than or equal to $1,000) associated with the depreciation of agency capital equipment and furnishings pursuant to AHA Guidelines. Examples include vehicles, computers, furniture, appliances and production equipment.

1800 - MISCELLANEOUS

1810 - Clothing: Cost of clothing purchased for consumers of the agency. *Report in the benefiting service center*.

1860 - Bad Debt: Cost associated with non-collectable amounts. *Direct assignment to Adjustments Column for those costs associated with Program Services. Production bad debts should be reported under Production.*

1890 - Other: Miscellaneous costs such as those associated with personal needs, recreation and leisure, interest on installment contracts, and interest on operating loans. **Please Note:** If the amount reported in the total column for this account equals or exceeds 20% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes tab for Schedule A.

Please Note:
Total Admin. & Support costs will be allocated based on total compensation costs. The Schedule A attachment is formulated to allocate the costs automatically. Please do not alter. These cells are protected so that the formulas cannot be changed.

TOTAL EXPENDITURES will be displayed automatically. These cells are protected; the formulas cannot be changed.

If the amount reported for Other expenses (accounts 1190, 1290, 1390, 1490, 1590 and 1890) equals or exceeds the percentage of the agency's total expenses indicated in the account description, the cell will be highlighted to remind the agency to attach a breakdown of expenses by type and cost.

3. COST REPORT: SCHEDULE B – GROSS REVENUES

Columns and rows highlighted in gray (on the templates) are completed by DHS staff.

A. HORIZONTAL AXIS: TOTAL AND ADJUSTMENT COLUMNS/SERVICE CENTERS

The horizontal axis of Schedule B - Gross Revenues is comprised of the following:

Total - This column represents the total revenue from the operating statement of the organization for the reporting period. The grand total of revenues must reconcile to the independently audited financial statements.

Adjustments - This column represents additions or deletions from the total column.

Administration and Support - Revenue from administration and support services.

Fund Raising - Revenue from fund raising activities.

DADA Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix C.

DDD Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix A.

DMH Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix B.

DRS Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix D.

Housing Services - Revenue from housing services.

Food Services - Revenue from the delivery of food services.

Production - Revenue from production activities.

Other DHS Program Services - Revenue received for DHS Program Services other than those identified as DADA Program Services, DDD Program Services, DMH Program Services or DRS Program Services.

Non - DHS Program Services - Revenue received for services other than DHS Program Services.

B. VERTICAL AXIS - CHART OF ACCOUNTS

2000 - FEES
Dollars received for services provided to consumers.

2020 - Title XIX: Dollars received from DHS, Local School Districts and consumers for services provided within the scope of South Dakota's approved Title XIX State Plan/Waiver for consumers.

2045 - SD Department of Education: Dollars received for services provided to consumers under 21 years of age, when not participating with ICF/MR or HCBS.

2055 - Client Pay: Dollars received from private pay clients as payment for services.

2060 - Insurance: Dollars received from insurance companies as payment for services.

2065 - Other States: Dollars received from other states for services provided to consumers.

2070 - Room and Board: Dollars received for room and board.

2075 - Bureau of Indian Affairs: Dollars received for services provided to Native American consumers, when not participating with ICF/MR or HCBS.

2090 - Other: Dollars received from other sources (including DHS contract funds) as payment for services provided to consumers.

2100 – GRANTS
Dollars received from City, County, State or Federal Government or other sources when expenses relating to a specific grant are incurred. Dollars received are for a specific consumer(s), position(s) or project(s). Dollars can also be received from other sources for services provided to clients.

2200 – CONTRIBUTIONS
Dollars donated or restricted for a specific service(s); report under the appropriate service(s). Documentation supporting the restriction must be available for review by Department staff.

2300 - OTHER INCOME

2310- Commodities, Food Stamps, National School Lunch: The value of commodities and food stamps received and the amount of National School Lunch revenue.

2340 – FmHA Rent Subsidy: The amount of subsidy from FmHA.

2341 – Section 8 Assistance: The amount of Section 8 Assistance.

2350 - Transportation: Includes, but is not limited to, reimbursement from the Department of Social Services, Office of Adult Services and Aging.

2360 – Production: Revenue from production activities.

2390 – Other: Dollars received from other sources for services provided to clients

Note: Revenues shall be directly assigned to the benefiting service/program column.

***TOTAL REVENUES* will be displayed automatically. These cells are protected; the formulas cannot be changed.**

4. COST REPORT ATTACHMENTS

A. ATTACHMENT 1 - STAFF

All providers shall prepare and submit Attachment 1 annually for all personnel for whom costs were reported in accounts 1010, 1020 and 1040 on Schedule A.

Columns highlighted in gray are completed by DHS staff.

Staff Credentials: Education above high school and licenses or designations held. *For Example: BBA, CCDC II, QMHP, etc.*

Position Number: The agency will assign a position number to each position in the agency. The position number will remain the same regardless of how many different individuals fill the position.

Example: Position #122 was filled by Mary Rose. Mary left the agency and Charlie Blue was hired to replace her. Charlie Blue's position number is #122.

A position cannot be occupied by more than one person at one time with the exception of overlap in occupancy due to training. For example, if Mary Rose remained on duty for two weeks to train Charlie Blue, the position number would remain #122 for both Mary and Charlie.

Position Title: Enter the title of each individual employee (i.e. Secretary, Residential Aid, Registered Nurse, etc.). A separate line should be used for each position.

Staff Name: Enter the name of each individual employee.

Start Date: Enter the date that the individual began employment with your agency. If the individual has been employed for more than a year, use the first day of the current fiscal year.
End Date: Enter the date the individual terminated employment with your agency. If the individual is currently employed with your agency, enter the end date of the current fiscal year.

Total Hours Paid: Enter the total number of hours for which the employee was paid during the reporting period.

Salary: Enter the individual's gross salary for the reporting period. Only those employees who are paid a *salary* would be reported in this column. Hourly employees are reported in the **Hourly** column.

Hourly: Enter the employee's hourly wage. Use the hourly wage earned at the end of the reporting period.

Bonus: Enter bonuses paid. This includes bonuses, incentive payments, balloon/one-time payments, profit sharing, etc.

Total Wages Paid: Enter the total wages paid to the employee for hours worked during the reporting period. Do not include amounts reported in the **Bonus** column in the **Total Wages Paid** column.

# of Hours: Enter the number of hours the employee worked in each service center. The total of these columns will equal the amount in the **Total Hours Paid** and the **Total Hours** columns.

Total Hours: The sum of the hours reported in the **# of Hours** columns will be calculated automatically. This will equal the hour reported in the **Total Hours Paid** column.

B. ATTACHMENT A - NOTES TO SCHEDULE A

Use this attachment to describe line item expenses.

a. Adjustment column items
b. Reconciliation between Audited Financial Statement and Schedule A
c. Breakdown of expenses by type and cost for those accounts exceeding the percentage limit
d. An explanation of any amounts reported in account 1090 - Payroll Accruals
e. Any other notes you may want to provide

C. ATTACHMENT B - NOTES TO SCHEDULE B

Use this attachment to describe line item revenues.

a. Adjustment column items
b. Reconciliation between Audited Financial Statement and Schedule B
c. Breakdown of revenue for other accounts (2090 and 2390)
d. Any other notes you may want to provide

5. APPENDIX

APPENDIX A
Division of Developmental Disabilities Program Services (Horizontal Axis)

For all DD Program Services, activities such as orientation, staff training, personnel management and staff supervision, paperwork, and quality assurance are to be included in the cost of providing services. The cost report will accommodate the recording of these and other similar activities that are a necessary part of providing the following services.

(03) Service Coordination - Services to assist individuals to gain access to needed medical, habilitative, social, and other related services and supports such as guardianship, legal, self-advocacy, housing, follow-up/outreach, referral or financial/payee assistance. In order to be considered service coordination, these services must be provided by the staff responsible for overall service coordination of an individual's plan. Salaries and benefits for staff such as service coordination aides and secretaries should also be included in this service center.

(04) Residential Services - Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings, including but not limited to, acquisition, retention, or improvement in skills related to activities of daily living.

Residential services may be provided in the following settings

1. "Foster homes" are adult foster homes licensed by the Department of Health, or children's foster homes licensed by the Department of Social Services.
2. "Family homes", i.e., living "with parents, relatives or guardian."
3. Supported Living Level 1: People need and receive services and supports from staff 24 hours daily.
4. Supported Living Level 2: People need and receive services and supports from staff during all waking hours.
5. Supported Living Level 3: All other residential services.

Home Size

1. In foster care settings, home size is determined by the number of people for whom residential services are provided within a home.
2. In family homes, home size is determined by the number of people for whom residential services are provided within a home.
3 In Level 1 - 2, home size is established by the number of people supported by the agency who are residing at that address. This number is established on an annual basis and is subject to change through the significant change process.
4. In Level 3, home size is established by the number of people supported by the agency living in an apartment or house.

(06) Day Services - Assistance with acquisition, retention, or improvement in self-help, socialization, adaptive and safety skills, compliance, attending to task and task completion, and problem solving, communication skills, gross and fine motor skills, and the reduction of maladaptive behavior, which takes place in a non-residential setting, separate from the home in which the individual resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an

adjunct to other day activities included in an individual's plan of care. Services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. Services may serve to reinforce skills or lessons taught in school, therapy or other settings. Services provided to individuals supported on **work crews** and **work enclaves**, and pursuant to an individualized education plan (IEP) are considered Day Services.

Day Hours
Day hours are the total of all sheltered workshop, mobile crew, enclave "hours per week" and Non Paid Activities ("Non Paid Hours per Week") from the Day Hours screen in the Service Record. The number of hours a person receives day services is determined by the hours of staff supervision provided, including transportation time. This includes **all** alternative service hours and transportation hours. *Rule of thumb - Any staff supervised hours during the day that do **not** include residential activities such as bathing, laundry, cleaning residential areas and cooking.

(07) Supported Employment Services - Paid employment for people who need intensive ongoing support to perform in a work setting, and are not yet able to be competitively employed at or above minimum wage. Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported employment services are directed towards assisting individuals to retain paid employment in community setting. These services include job finding and job placement activities.

Supported Employment Services Hours
The number of hours a person receives supported employment services is determined by the hours of staff supervision while at work. Supported Employment hours is the total number of "hours per week" identified on the Supported Employment Screen in the Service Record, and includes **only** independent job placements.*

Note: Sum the above two numbers for total Daytime Hours.
**May NOT exceed 80 hours.*

(08) Nursing Services - Medical services provided by a registered nurse or licensed practical nurse (in accordance with state law) which include screenings and assessments, nursing diagnosis, treatment, staff training, monitoring of medical care and related services, policy and procedure development and review, and response to medical emergencies. Also includes staff activities such as tuberculin tests, phlebotomy for hepatitis screenings, etc. Salary and benefits for staff such as nursing aides and nursing secretaries should also be included in this service center.

Medical Services: For Speech, Hearing & Language, Medical Equipment & Drugs, and Other Medical Services expenditures, report those expenditures on the cost report that are not directly covered by the Medicaid State Plan. Costs associated with these services that are incurred by the agency (regardless of if the service is reported on the service record) should be reported as expenses on the agency's cost report.

(09) Speech, Hearing, & Language Services (Unduplicated count of consumers) - Services provided by qualified professionals including evaluation, program design, direct services, staff training, and policy and procedure review. Communication programs and related services to

improve general socialization skills would not be included, unless they are developed to reduce or eliminate certain undesired effects of a specific speech/language disorder.

(10) Medical Equipment & Drugs (Unduplicated count of consumers) - 1) Devices, controls, and appliances which enable individuals to increase/improve their ability to perform activities of daily living or perceive control or communicate with their environment. Also included are costs associated with repair of equipment and devices. Organizations that have a staff member who performs these duties, should allocate a portion of their salary and benefits to this service center. 2) Drugs, chemicals or preparations for the prevention, relief or cure of diseases, including prescribed nutritional supplements.

(11) Other Medical Services (Unduplicated count of consumers) - Services performed by a qualified medical professional such as a physician, psychologist, physical therapist, occupational therapist, pharmacist, optometrist, dentist or dietitian. (If the dietitian is consulting on agency menus, rather than a specific dietary plan for a specific individual, then the expense should appear in the Food Service center.) Includes evaluation, diagnosis, treatment, design and monitoring of programs/services, policy and procedure development and review, and staff training activities. Salary and benefits for staff that have significant duties related to restorative therapies should also be included in this service center.

(12) Housing Services - Buildings, furnishings, supplies, utilities, local telephone service, depreciation, interest, and maintenance costs to provide housing for individuals needing such services.

Note: A unit of housing is defined as having a bed available/reserved for a specified consumer, regardless of whether they occupy it every night (not capacity).

(13) Food Services - Food, related dietary items, equipment (including major appliances for cooking and storing food), materials for preparation, serving, and storage, and staff or dietary consultant costs associated with the delivery of food services which are needed to meet the specified nutritional needs of individuals receiving services.

Note: A unit of meal service is defined as an actual meal served to a consumer.

(14) Production - Enterprises related to producing marketable goods or services for sale by the agency or another organization under a sub-contract agreement. Expenses associated with marketing, product development, labor, materials, quality control, and sales are reported under this service center.

APPENDIX B
Division of Mental Health Program Services (Horizontal Axis)

For all MH Program Services, activities such as orientation, staff training, personnel management and staff supervision, paperwork, and quality assurance are to be included in the cost of providing services. The cost report will accommodate the recording of these and other similar activities that are a necessary part of providing the following services.

CARE Program - A CARE Program shall be a self-contained program which is the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness. The CARE Program is aimed at helping people with a severe and persistent mental illness live successfully in the community. A CARE Team is a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team, supervised by a clinical supervisor. Services should stress integration in normal community settings and be responsive to cultural differences and special needs. Outreach to consumers and provision of services according to individual consumer needs shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. Referrals of consumers to other program entities for treatment, rehabilitation and support services may be made as clinically appropriate. The CARE Team shall maintain written policies and procedures for the delivery of services per the requirement outlined in Contract Attachment 2. Allowable activities in the CARE Program are:

1. Case Management
2. Crisis assessment and intervention
3. Symptom assessment, management and supportive counseling
4. Medication prescription, administration, monitoring and documentation
5. Direct assistance to ensure that the consumer obtains the basic necessities of daily life
6. Direct assistance with structuring and performing basic daily living activities
7. Development of psychosocial skills for enhancing independent living skills
8. Minimizing consumer involvement with the criminal justice system
9. Assistance and support in helping consumers find and maintain employment in community-based job sites
10. Active participation, as clinically appropriate, of the consumer's family and supportive social network to assist them and the consumer to relate in a positive and supportive manner
11. Liaison services

*NOTE – Report all Psychiatric and CNP/PA services on the **Psychiatric and CNP/PA** column.

Room and Board - Residential housing provides for the room and board of individuals ages 18 and older who have a severe and persistent mental illness and who, due to their illness, are unable to function in an independent living arrangement. Individuals living in Residential Housing will be provided, as appropriate, the broad range of services available through the CARE Program. Services provided by Residential Housing are limited to room and board. Report costs associated with the operation and maintenance of the building under Room and Board; report costs associated with actual CARE services under the CARE Program. If the staff in the

residential facility performs a function that meets the CARE contact criteria, the cost of that function is reported in the CARE Program. All other costs related to keeping the residence open and appropriately staffed are reported as Room and Board.

IMPACT Program - An IMPACT Program shall be a self-contained program, which is the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified consumers who are the most severely mentally ill and require the most intensive services. The IMPACT Program serves consumers who have historically failed in community settings and who have had frequent hospitalizations. The IMPACT Program is aimed at helping people with severe and persistent mental illness live successfully in the community and reduce the need for repeated or prolonged psychiatric hospitalizations. An IMPACT Team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one services delivery system, supervised by a clinical supervisor. Services should stress integration in normal community settings and be responsive to cultural differences and special needs. Outreach to consumers and provision of services according to individual consumer needs shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. Referrals of consumers to other program entities for treatment, rehabilitation and support services may be made as clinically appropriate. The IMPACT Team shall maintain written policies and procedures for the delivery of services per the IMPACT Contract Attachment. IMPACT services may not exceed a ratio of at least one (1) primary therapist for every 12 consumers served. An IMPACT agency must provide each consumer with an average of 20 contacts per month and a minimum of one (1) face-to-face contact each week with IMPACT clinical staff, and more often if clinically indicated.

Emergency Services - Emergency contact services available 24 hours per day, seven days a week, for persons experiencing a mental health emergency or crisis. Emergency services are designed to stabilize the emergency situation and to provide immediate treatment in the least restrictive environment possible. Services shall be coordinated with other community resources for referral purposes.

Outpatient Services (Non SPMI CARE, Non SED Services) - Nonresidential diagnostic and treatment services which are goal oriented, include an individualized treatment plan, and are provided by staff trained and experienced in mental health. Allowable activities, as defined in the activity codes, included in outpatient services are:

1. Individual Therapy/Counseling - Contact between a consumer and therapist in which the therapist delivers direct therapy/counseling to assist the consumer in progress toward therapeutic goals. Collateral contacts are not reported.
2. Group Therapy - Face-to-face contact between a therapist and two or more consumers in which the therapist delivers therapies/counseling to multiple consumers, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy progress notes relate to the group therapy process that must include each individual consumer's level of participation in the session and progress toward achieving individualized goals noted on the treatment plan. Reimbursement for consumers receiving group therapy will be at one-half the unit rate per consumer. A maximum of ten (10) consumers is billable per group session.
3. Family Therapy - Treatment with the focus on family relationships and roles. Each member of the family is considered a consumer and the services delivered to each consumer are reported in the record(s). One progress note can be used per

session if the note includes each member's level of participation and progress toward achieving the specified goals noted on the treatment plan. Reimbursement for consumers receiving family therapy will be at one-half the unit rate per consumer.

4. Screening/Evaluation/Examination/Interpretations - Contact where the primary purpose is to develop information regarding a person's emotional state, and/or social history for use in formulating goals. May be performed for the purpose of assisting other agencies with case disposition. Screening and evaluation includes psychosocial, psychological and psychiatric examinations for diagnosis and treatment recommendation, including write-up time. Screening of patients for admission to the Human Services center and other inpatient facilities is also included.
5. Collateral Contacts - Treatment of a consumer through necessary telephone or personal contact with persons other than the consumer to obtain information necessary to plan appropriate treatment or to assist others so they can respond therapeutically regarding a consumer's problem. May be provided only in conjunction with screening, evaluation, examination, interpretation, individual therapy, family therapy, group therapy, or medication evaluation and monitoring.

*NOTE – Report all Psychiatric and CNP/PA services on the **Psychiatric and CNP/PA** column

Psychiatric and CNP/PA Services

1. Medication Evaluation and Monitoring by a Physician or Psychiatrist - Contact with the primary purpose of prescribing or reviewing a consumer's use of pharmaceuticals. May be delivered by a physician, psychiatrist, or other allied health professional under the supervision of a psychiatrist or physician.
2. Medication Evaluation and Monitoring by a Certified Nurse Practitioner or Physician's Assistant - Contact with the primary purpose of prescribing or reviewing a consumer's use of pharmaceuticals. May be provided by a certified nurse practitioner or a physician's assistant (within the scope of practice). Administration of medication is not a billable service. Services provided by a nurse are not billable.

*NOTE -- If a Psychiatrist also serves as Medical Director, the associated time and expense for his/her direct care services should be allocated to the Psychiatric service center. Time and expense associated with Medical Director services are allocated to the benefiting service center.

S.E.D. Children's Mental Health Services - An intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care which delivers mental health services to children with a serious emotional disturbance. The SED program shall provide access to a comprehensive array of services that address a child's physical, psychological, emotional, social and educational needs. The SED program shall provide children with individualized services in accordance with the unique needs and potentials of each child. These services shall be provided to children within the least restrictive, most normative environment that is clinically appropriate, and in a manner that is sensitive and responsive to children's cultural differences and special needs. The parents, families and surrogate families of children with SED will be full participants in all aspects of the evaluation, planning, and delivery of SED services, which shall be integrated with all involved child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in the home community, whenever possible. The following activities are designed to be utilized according to the needs of the child/family:

1. In-home individual therapy - Face-to-face contact between an identified child and therapist, in which the therapist delivers direct therapy to assist the consumer in progress toward case service plan goals. If this service is not delivered in the child's home, the more appropriate setting used should be justified and documented in the clinical record.
2. In-home family education/support/therapy - Face-to-face contact between two or more family members and therapist in which the therapist delivers direct therapy, education relating to the child's psychiatric condition, or support services to develop coping skills for the parents and family members, in regards to the identified child.
3. Crisis intervention - An immediate therapeutic response available 24 hours a day which involves direct telephone or face to face contact with consumers exhibiting acute psychiatric symptoms and/or inappropriate behavior, that left untreated, presents an immediate threat to the child or others. Crisis intervention also includes direct telephone or face-to-face contacts with family members or other service providers in an attempt to effectively manage the child's crisis.
4. Collateral contacts - Treatment of an individual through necessary telephone or personal contact with persons other than the identified child. This information is necessary to plan appropriate treatment, to assist others so they can respond therapeutically regarding the child's difficulty/illness, or to link the child/family to other necessary and therapeutic community supports.
5. Case Management - Services which assist the child/family in gaining access to, and building collaboration and coordination among family, caretakers, medical, social, education, community resources, and other services and support the child and family in meeting the goals and objectives of the Case Service Plan. Case management performs direct service as well as service coordination. Crisis issues are dealt with and ongoing problem solving is accomplished. Services may be face to face or by telephone with the consumer, consumer's family, significant others, or service providers.
6. Assessment and Evaluation – A face-to-face contact meeting between or under the supervision of a qualified mental health professional or a clinical supervisor and the child, resulting in a written evaluation of a set of symptoms. The process may result in the indication of a mental disorder or a condition requiring treatment, as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R or DSM-IV).
7. Psychological Evaluation - Such services must be provided by or under the supervision of a licensed psychologist.
8. Group Therapy for Children with SED - Goal directed, face-to-face therapeutic intervention with the eligible child and one or more children with SED who are treated at the same time. The group focuses on the mental health needs of the consumers in the group(s).
9. Parent/Guardian Group Therapy – Goal directed face-to-face therapeutic intervention with the parents/guardians of an eligible child and one or more parent/guardians of children with SED, who are treated at the same time. The group focuses on the mental health needs of the children with SED.
10. Intensive Family Services (IFS) – Services provided to families of youth under the jurisdiction of the Department of Corrections which focus on resolving issues related to the child's successful return to home. Families served by IFS are exempt from the SED eligibility criteria.
11. Liaison Services – Liaison services must be consistent with treatment goals and intended to minimize the length of hospitalization. Services in the community include the development of community resources, coordination with other support

networks and contacts with the individual's family. All activities should provide for a continuing contact with the child and family, to assure that changing needs are recognized and appropriately met. Liaison services must be provided to facilitate treatment planning and coordination of services between mental health centers and the following entities:

1. In-patient Psychiatric Hospitalization;
2. Residential Programs
3. Local Hospitals
4. Correctional Facilities; and
5. In-patient Drug/Alcohol Treatment Programs.

*NOTE – Report all Psychiatric and CNP/PA services on the **Psychiatric and CNP/PA** column.

APPENDIX C
Division of Alcohol and Drug Abuse Program Services (Horizontal Axis)

TREATMENT CODE DEFINITIONS

EARLY INTERVENTION – A non-residential program that provides early intervention services to individuals who may have substance use related problems, but do not appear to meet the diagnostic criteria for Substance-Related Disorder.

H0007 **Direct client support: (Core Service Agencies only)** Either an initial or a treatment needs assessment in accordance with ARSD 46:05:09:07 or 46:05:09:08. A unit of service is 15 minutes.

T1007 **Indirect Client Support: (Core Service Agencies only)** Indirect services such as referral to other resources which offer educational, vocational, social, psychological, employment, medical, court, and other related alcohol and drug services as needed by the client. Includes liaison with other resources and agencies. A unit of service is 15 minutes.

H0001 **Non-Core Agency Assessments:** Either an initial or a treatment needs assessment in accordance with ARSD 46:05:09:07 or 46:05:09:08. A unit of service is 15 minutes.

H0001 HV **Gambling Assessment:** A gambling assessment in accordance with ARSD 46:05:21:04(1). A unit of service is 15 minutes.

OUTPATIENT TREATMENT – A non-residential program that provides chemically dependent/abuse clients a clearly defined, structured treatment program on a scheduled basis.

H0004 **Local/Home-Based Individual Counseling:** Individuals must meet the criteria for services under ARSD 46:05:15 and 46:05:09. These individuals are seen on an individual basis. Clients receiving Home-Based Services must be referred to the program from Home Based Service Providers from the local Mental Health Center. A unit of service is 15 minutes.

H0005 **Local Group Counseling:** This category is for a minimum of three and a maximum of 13 clients. Each group member must meet the criteria for services under ARSD 46:05:15 and 46:05:09, have a treatment needs assessment completed, a treatment plan developed and must be receiving services at the accredited program's home station. A unit of service is 15 minutes.

H0004 TN **Rural/Home Based Individual Counseling:** Individuals must meet the criteria for services under ARSD 46:05:15 and 46:05:09, and must be receiving services at least 20 miles from the home station. Clients receiving Home Based services must be referred to the program through the Home Based Program from the local Mental Health Center. A unit of service is 15 minutes.

H0005 TN **Rural Group Counseling:** This category is for a minimum of three and a maximum of 13 clients. Each group member must meet the criteria for services under 46:05:15 and 46:05:09, have a treatment needs assessment completed, a treatment plan developed, and must be receiving services at least 20 miles from the home station. A unit of service is 15 minutes.

T1006 **Local/Home Based Family Counseling:** This category is for those family members harmfully affected by the alcohol and or drug use of another family member or significant other person. Each family member must have completed a treatment needs assessment and a family treatment plan, and must be receiving services at the home station. Clients receiving Home Based services must be referred to the program through the Home Based program from the local Mental Health Center. A unit of service is 15 minutes.

T1006 TN **Rural/Home Based Family Counseling:** This category is for those family members harmfully affected by the alcohol and or drug use of another family member or significant other person. Each family member must have completed a treatment needs assessment and a family treatment plan, and must be receiving services at least 20 miles from the home station. Clients receiving Home Based services must be referred to the program through the Home Based program from the local Mental Health Center. A unit of service is 15 minutes.

H0004 HV **Gambling Local/Home Based Individual Counseling:** Individuals must meet the criteria for services under ARSD 46:05:21 and 46:05:15 and 46:05:09. These individuals are seen on an individual basis. Clients receiving Home Based services must be referred to the program through the Home Based program from the local Mental Health Center. A unit of service is 15 minutes.

H005 HV **Gambling Local Group Counseling:** This category is for a minimum of three and a maximum of 13 clients. Each group member must meet the criteria for services under ARSD 46:05:21, 46:05:15 and 46:05:09, have a treatment needs assessment completed, a treatment plan developed and must be receiving services at the accredited program's home station. A unit of service is 15 minutes.

INTENSIVE OUTPATIENT TREATMENT – A non-residential program that provides chemically dependent/abuse clients a clearly defined, structured, intensive treatment program on a scheduled basis.

H0015 HD **Intensive Outpatient Treatment for Pregnant Women/Women with Dependent Children:** Clients meeting this category must be pregnant and/or have dependent children. Women involved in structured outpatient treatment must meet the criteria for services under ARSD 46:05:16 and 46:05:09. In addition, programs must comply with Public Law 102-321 Section 508. A unit of service is 15 minutes.

H0015 **Adult Intensive Outpatient Treatment:** Individuals must be 18 years of age or over and must meet the criteria for services under ARSD 46:05:16 and 46:05:09. A unit of service is 15 minutes.

H0015 **Adolescent Intensive Outpatient Treatment:** Individuals must be less than 18 years of age and meet the criteria for services under ARSD 46:05:16 and 46:05:09. A unit of service is 15 minutes.

H0015 HF **Intensive Outpatient Treatment (SLIP SLOT):** Clients for this category must receive prior approval by the Division of Alcohol and Drug Abuse. Individuals must meet the criteria for services under ARSD 46:05:16 and 46:05:09. There is a special emphasis on relapse prevention planning. A unit of service is 15 minutes.

H0015 HV **Gambling Intensive Outpatient Treatment:** Individuals must be 18 years of age or over and must meet the criteria for services under ARSD 46:05:21, 46:05:16 and 46:05:09. A unit of service is 15 minutes.

DAY TREATMENT – A program providing a minimum of 20 hours of structured intensive treatment services per week. Phase I clients will be involved in the program while living at the facility. Phase II clients will be involved in a 12 week continuing care program and will not be living at the facility.

H2012 **Day Treatment:** Individuals must meet the criteria for services under ARSD 46:05:17 and 46:05:09. A unit of service is one day.

H2012 HD **Day Treatment for Pregnant Women/Women with Dependent Children:** Individuals must be pregnant or substance abusing females with dependent children. They must meet the criteria for services under ARSD 46:05:17 and 46:05:09. In addition, programs must comply with Public Law 102-321 Section 508. A unit of service is one day.

H2012 HV **Gambling Day Treatment:** Individuals must meet the criteria for services under ARSD 46:05:21, 46:05:17 and 46:05:09. A unit of service is one day.

MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT – A residential treatment program of subacute care which provides medically monitored structured and intensive treatment for chemically dependent clients.

H0018 **Adult Medically Monitored Intensive Inpatient Treatment Program:** Individuals must be 18 years of age or over and must meet the criteria for services under ARSD 46:05:19 and 46:05:09. A unit of service is one day.

H0018 HD **Medically Monitored Intensive Inpatient Treatment for Pregnant Women/Women with Dependent Children:** Individuals must be pregnant or be a substance abusing female with dependent children. They must receive services required under ARSD 46:05:19 and 46:05:09. In addition, programs must comply with Public Law 102-321 Section 508. A unit of service is one day.

H0018 **Adolescent Medically Monitored Intensive Inpatient Treatment Program:** Individuals must be less than 18 years of age and meet the criteria for all services required under ARSD 46:05:19 and 46:05:09. A unit of service is one day.

H2012 HV **Gambling Medically Monitored Intensive Inpatient Treatment Program:** Individuals must be 18 years of age or over and meet the criteria for all services required under ARSD 46:05:19 and 46:05:09. A unit of service is one day.

CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL – A residential, peer oriented treatment program of subacute care designed to aid the client's re-entry into society. The program must provide direct alcohol and drug counseling, and support service counseling by referral. The program shall provide case management services that will help clients to find employment, and to coordinate other services as may be necessary to facilitate the client's successful re-entry into the community.

H0016 HF **Clinically Managed Low Intensity Residential Treatment (SLIP SLOT):** Individuals must have prior approval by the Division of Alcohol and Drug Abuse. Clients are housed at the agency and go through the Intensive Outpatient Treatment Program with a special emphasis on relapse prevention planning. Clients must meet the criteria for services under ARSD 46:05:20 and 46:05:09. A unit of service is one day.

H0016 HA **Clinically Managed Low Intensity Residential Program for Adolescents:** Individuals must be less than 18 years of age and meet the criteria for services required under ARSD 46:05:20 and 46:05:09. The Level III.1 criteria will apply to programs that provide transitional care for adolescents. A unit of service is one day.

H0016 **Clinically Managed Low Intensity Residential Program:** Clients must meet the criteria for services under ARSD 46:05:20 and 46:05:09. A unit of service is one day.

H0016 **Clinically Managed Low Intensity Residential Program (Women):** Individuals must meet the criteria for all services required under ARSD 46:05:20 and 46:05:09. A unit of service is one day.

H0016 HD **Clinically Managed Low Intensity Residential Programs for Pregnant Women or Women with Dependent Children:** Individuals must be pregnant substance abusing women and/or substance abusing women with children and must meet the criteria for services under ARSD 46:05:20 and 46:05:09. In addition, programs must comply with Public Law 102-321 Section 508. A unit of service is one day.

H0016 HA HD **Clinically Managed Low Intensity Residential Programs for Pregnant Adolescent/Adolescents with Dependent Children:** Individuals must be pregnant substance abusing adolescents and/or substance abusing adolescents with children and must meet the criteria for services under ARSD 46:05:20 and 46:05:09. In addition, programs must comply with Public Law 102-321 Section 508. A unit of service is one day.

RESIDENTIAL DETOXIFICATION – A clinically managed residential detoxification program providing for the supervised withdrawal from alcohol or drugs of person without known serious physical or immediate psychiatric complications.

H0014 **Clinically Managed Residential Detoxification:** Individuals must meet the criteria for services under ARSD 46:05:18 and 46:05:09. A unit of service is one day. Clients must be involved in a minimum of 24 hours and can be involved in this level of care until they no longer meet ASAM criteria for continued stay.

PREVENTION CODE DEFINITIONS

H0024 **Information Dissemination:** Services include providing awareness and knowledge of the nature and extent of alcohol and drug use, abuse, addiction and/or violence and their effects on individuals, families and communities. They provide knowledge and awareness of available prevention programs and services, and are characterized by one-way communication. Examples include speaking engagements, media promotion, technical assistance and newsletters**.**

H0025 **Education:** The interaction between the prevention professional and the client participant is the basis of this strategy. The activities involved aim to affect critical life and social skills, refusal skills, and critical thinking skills. Services are characterized by two-way communication. Examples include classroom presentations, parenting and family management classes and peer leader/helper programs.

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H0026 **Community Based:** Services enhance the ability of a community to provide effective violence, and/or alcohol and other drugs abuse prevention services. The activities include planning, interagency collaboration, coalition building, and networking. Examples include multi-agency coordination and collaboration, community and volunteer training, and systemic planning/

H0029 **Alternatives:** A service strategy that provides for the participation of specific populations in activities free from violence, and/or alcohol , and other drug use. The intention of this strategy is to create attractive, healthy and safe activities that increase an individual's commitment to abstain from violence, and/or alcohol and drugs. These activities provide opportunities for low risk choices when it comes to alcohol use and/or violent behavior. Examples include leadership camps, chemical free events and community centers.

H0027 **Environmental:** Services establish or change written and unwritten community standards, codes and attitudes that influence the incidence and prevalence of violence and/or the abuse of alcohol and other drugs used in the general population. Examples include formal and informal policy development,

H2014 **Resource Development:** Training specific for CCBT's or college courses for prevention providers.

Problem Identification and Referral: A prevention strategy that aims to identify individuals who have engaged in illegal/age-inappropriate use of tobacco, alcohol or other drugs. Services include employee assistance services, student assistance services, 10-hour diversion programs, 30-hour intensive prevention programs, and driving under the influence (DUI) education programs.

H0007 HA **Assessments:** Evaluations for youth under the age of 18.

H0028 HB **Young Adult Alcohol Diversion Program:** Eight hours of education/diversion program within the Circuit Court Districts for 19-20 year olds who have been referred to the program due to an alcohol related offense.

H0028 HA **Primary Prevention Programs:** Ten hours of education program within a community based setting for youth under age 18 who are first time offenders of alcohol or other drugs.

H0028 HK **Intensive Prevention Programs:** Thirty hours of IPP within a community based setting for adolescents who have multiple offenses of alcohol or other drugs.

APPENDIX D

Division of Rehabilitation Assistive Daily Living Services (Horizontal Axis)

CASE MANAGEMENT SERVICES - Services include prescreening general assessment, coordination of medical services, activities of daily living and cognitive skills assessments, facilitating a planning conference during which the Individual Service Plan is developed by the consumer and case manager, and ongoing, regular monitoring of the delivery of waiver services in accordance with the service plan.

CONSUMER PREPARATION SERVICES - Consumer Preparation services are provided to ensure the consumer is able to supervise and direct their personal attendant services on a daily basis. These services are provided as a safeguard to ensure the consumer's basic health and safety needs are being met through the provision of personal attendant services. Based upon any identified consumer need for such services, the individual service plan will reflect the need and services planned to address it. The services will be in areas such as medical self-care, activities of daily living, time management, and personal attendant management. The need and type of consumer preparation service will vary depending upon the nature of the consumer's disability and his/her experience in directing and supervision of personal attendants. Consumer Preparation services will not include educational, vocational or pre-vocational components.

PERSONAL ATTENDANT SERVICES - Personal Attendant Services (PAS) provides for personal attendants to complete tasks for the consumer which he/she is unable to do for him/herself, or those tasks which would take the consumer an exceptionally long time to do alone. Assistance provided through PAS enables the consumer to live more independently and perhaps to pursue such activities as school or work. The consumer requests PAS from an approved provider. Once the consumer is found waiver eligible for PAS and for Medicaid, the needed, planned and approved services can begin.

EMERGENCY RESPONSE SYSTEMS - Emergency response systems shall be provided to an eligible consumer in their residence. An emergency response system is an electronic device that enables individuals to alert neighbors and summons assistance in the event of an emergency. The device may either be a portable “help” button to allow for mobility or a small tabletop unit readily accessible to the individual. Some devices may be voice activated.

PRIVATE DUTY NURSING SERVICES - Private duty nursing services will be provided by a qualified registered nurse or licensed practical nurse that holds a current South Dakota Board of Nursing license. Persons providing private duty nursing services must be currently licensed by the State of South Dakota Board of Nursing. Under the direction of the individual’s physician, and in conjunction with the Case Manager, the private duty nurse will develop and implement a nursing plan of care. Private duty nursing services will be provided on an as needed basis.

INDEPENDENT LIVING SERVICES - Independent Living is control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities. This includes managing one's own affairs, participating in day-to-day life in the community, fulfilling a range of social roles, and making decisions that lead to self-determination and decreasing of psychological or physical dependence upon others.